COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

CLAIM FOR TRAVEL ADVANCE

DO NOT TYPE/ WRITE IN THIS AREA

OAD Date Received:_____ Date Travel Approved: _____

Request Number:_____ Date Travel Advance Approved/Denied: _____

DATE PREPARED: _____ UNIT NUMBER (Cost Center): _____

EMPLOYEE NAME: _____ EMPLOYEE NUMBER: _____

EMPLOYEE HOME ADDRESS (Optional): EMAIL ADDRESS: _____

_____ OFFICE OR CELL PHONE NUMBER: ( ) _____

(Street include apt. #)

_____ CONTACT PERSON: _____

(City and State)

CONTACT PHONE NUMBER: ( ) _____

AMOUNT REQUESTED: $_____ (Itemized amount requested)

(No more than 75% of the estimated travel expenses will be advanced for Lodging, Meals, and Ground Transportation; 100% of the Registration fees will be paid in advance, if applicable. Do not include Air Fare and Car Voucher, if applicable, in the travel advance amount requested.)

TRAVEL DATES: _____ DATE WARRANT REQUIRED: _____

DESTINATION: _____

(City and State)

JUSTIFICATION (Attach a separate page if additional justification is needed.):

To the Employee:

In accordance with the County Fiscal Manual, Chapter 12 – Los Angeles County Travel Policy the undersigned is required to prepare and submit an Expense Claim Form with receipts attached within two (2) weeks of completing the trip, to the:

Accounting Division - Expenditures Section
550 South Vermont Avenue, 8th floor
Los Angeles, CA 90020

It is understood that failure to promptly submit an Expense Claim Form covering a trip may result in a full deduction of the amounts advanced being taken from the employee's payroll warrant.

_____ _____

Employee's Signature Date

Approvals:

_____ _____

Executive Manager, District Chief/Program Head/Division Chief Signature Date

_____ _____

Director of Finance Signature Date

_____ _____

Department Head/Chief Deputy Director/Medical Director/Administrative Deputy Date